TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Compliance Toxicology

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-16-0419-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Compliance Toxicology LLC, rendered a urine drug test to the above reference claimant as ordered by the DWC treating physician. These charges were submitted to the carrier, along with the UDT report / LCMS confirmation. Texas Mutual denied the claim(s) based upon a veritable array of denial rationales including, "…do not meet ODG guidelines, lacks information, absence of precertification, documentation does not support, and services included in another procedure."

Amount in Dispute: $3,081.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor submitted the billing a second time that Texas Mutual received 5/14/15. This second billing reflected significant change in the coding. Because this second bill with the change codes constituted a new bill Texas Mutual denied payment, absent timely filing, of the G codes with message code 731. Texas Mutual has elected to pay codes G6042, G6031, G6044, G6056, G6053, 82542, 83789, 83788, 80184 and 80304. "

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 25, 2015	Urinary Drug Screen	$3,081.80	$19.21

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out the documents required to be filed with medical bills during

the medical billing process.

3. 28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.
4. 28 Texas Administrative Code §137.100 details concepts of disability management.
5. 28 Texas Administrative Code §134.203 sets out the reimbursement for clinical laboratory services.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: Explanation of benefits dated October 7, 2015
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 18 – Exact duplicate claim/service
   - 29 – The time limit for filing has expired
   - 225 – The submitted documentation does not support the service being billed we will re-evaluate this upon receipt of clarifying information
   - 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service
   - 758 – ODG documentation requirements for urine drug testing have not been met
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions

Issues

1. What codes will be reviewed as part of Medical Fee Dispute Resolution?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. Were the services in dispute recommended under the division's treatment guidelines?
4. Did the requestor meet division documentation requirements?
5. Did the carrier appropriately request additional documentation?
6. Did the carrier appropriately raise reasonableness and medical necessity?
7. Were Medicare policies met?
8. Is reimbursement due?

Findings

1. The services in dispute are for urinary drug screens. Review of the submitted medical claims finds different codes and amounts listed. The submitted DWC060 contains codes: G6042, G6031, G6044, G6056, G6053, G6045, G6046, G6052, 83992, G6056, G6056, 80360, G6058, G6031, G6030, 80184 and 80304. These codes will be reviewed per Division rules and guidelines.
2. The codes G6045, G6046, G6052, G6056, G6056, 80360, G6058, G6030 were denied with remark code 29 – "The time limit for filing has expired" and 731 – "Per 133.20(B) Provider shall not submit a medical bill later than the 95th day after the date the service." The carrier in their position statement states, "The requestor submitted the billing a second time that Texas Mutual received 5/14/15. This second billing reflected significant change in the coding. Because this second bill with the change codes constituted a new bill Texas Mutual denied payment, absent timely filing, of the G codes with message code 731."

   The date of service in dispute is February 25, 2015. Per the carrier's statement a "new bill" was received on May 14, 2015. This received date is within 95 days of the date of service. Therefore the carrier's denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.
3. Per 28 Texas Administrative Code (TAC) §137.100 (a) states, in pertinent part, that "Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp..."* Review of the February 2015 ODG pain chapter under the "Drug testing" and "procedure description finds that drug testing is "Recommended as an option…" Furthermore, ODG refers to procedure description "Urine Drug Testing (UDT)" where UDTs are described as "Recommended as a tool to monitor adherence to use of controlled substance treatment, to identify misuse (both before and during treatment), and as an adjunct to self-report of drug use." The division concludes that the services were

provided in accordance with the division's treatment guidelines; that the services are presumed reasonable pursuant to 28 TAC §137.100(c), and Labor Code §413.017; and are also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

4. The respondent's claim adjustment code 758 states that "ODG documentation requirements for urine drug testing have not been met." Documentation requirements for the services provided are not established by ODG, rather, documentation requirements are established by 28 TAC §133.210 which describes the documentation required to be submitted with a medical bill. 28 TAC §133.210 does not require documentation to be submitted with the medical bill for the services in dispute. The carrier's denial reason is not supported.
5. The carrier denied payment, in part, with claim adjustment code 225 citing that the documentation does not support the service billed, and that the carrier would "…re-evaluate this upon receipt of clarifying information." Similarly, in its response to this medical fee dispute, the carrier cites the lack of clarifying information and/or documentation as a reason for denial of payment. The process for a carrier's request of documentation not otherwise required by 28 TAC 133.210 is detailed in section (d) of that section as follows: "Any request by the insurance carrier for additional documentation to process a medical bill shall:
    (1) be in writing;
    (2) be specific to the bill or the bill's related episode of care;
    (3) describe with specificity the clinical and other information to be included in the response;
    (4) be relevant and necessary for the resolution of the bill;
    (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
    (6) indicate the specific reason for which the insurance carrier is requesting the information; and
    (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation."

    No documentation was found to support that the carrier made an appropriate request for additional documentation during the billing process with the specificity required by rule. The division concludes that carrier failed to meet the requirements of 28 TAC 133.210(d).
6. The insurance carrier in its response makes assertions that question the appropriateness and medical necessity of the services in dispute. Although these assertions are made based on language taken from the ODG, the issues raised indicate that the insurance carrier is denying payment based on medical necessity. Health care provided in accordance with the ODG is presumed reasonable as specified in (c) of Rule §137.100. Section (e) of that same rule allows for the insurance carrier to retrospectively review reasonableness and medical necessity:

    > "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

    28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage. Applicable 28 TAC §19.2003 (b)(31) defines retrospective review as "A form of utilization review for health care services that have been provided to an injured employee." No documentation was found to support that the insurance carrier retrospectively reviewed the reasonableness and medical necessity of the service in dispute pursuant to the minimal requirements of Chapter 19, subchapter U as required. The insurance carrier failed to follow the appropriate administrative process and remedy in order to address its assertions regarding appropriateness of care and medical necessity.

7. The carrier denied the disputed service as 892 – "Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions." 28 TAC §134.203 (b) states,

    > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers'

compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiative (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Review of the medical bill finds that current AMA CPT codes were submitted. The requestor met 28 TAC §134.203(b) for these disputed codes.

8. 28 TAC §134.2(e) states,

The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and

(2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."

CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a possible professional component, for that reason, the MAR is determined solely pursuant to 28 TAC §134.203(e)(1). The maximum allowable reimbursement(MAR) for the services in dispute is 125% of the fee listed for the codes in the 2014 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov. The total MAR is calculated as follows:

- Procedure code 80360, service date February 25, 2015, has a status indicator of X, which denotes items and services subject to statutory exclusion. No payment is recommended.
- Procedure code G6058, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $18.03. 125% of this amount is $22.54.
- Procedure code G6031, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $25.17. 125% of this amount is $31.46 at 2 units is $62.92.
- Procedure code G6030, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $24.36. 125% of this amount is $30.45.
- Procedure code 80184, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $15.58. 125% of this amount is $19.48.
- Procedure code 80304, service date February 25, 2015, has a status indicator of X, which denotes items and services subject to statutory exclusion. No payment is recommended.
- Procedure code G6042, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $21.15. 125% of this amount is $26.44 at 2 units is $52.88.
- Procedure code G6031, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $25.17. 125% of this amount is $31.46 at 2 units is $62.92.
- Procedure code G6044, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $20.62. 125% of this amount is $25.78 at 2 units is $51.56.
- Procedure code G6056, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $26.48. 125% of this amount is $33.10 at 5 units is $165.50.
- Procedure code G6053, service date February 25, 2015. The fee listed for this code in the

Medicare Clinical Fee Schedule is $22.22. 125% of this amount is $27.78 at 2 units is $55.56.

- Procedure code G6045, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $28.10. 125% of this amount is $35.13.

- Procedure code G6046, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $34.98. 125% of this amount is $43.73.

- Procedure code G6052, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $23.98. 125% of this amount is $29.98.

- Procedure code 83992, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $20.00. 125% of this amount is $25.00 at 2 units is $50.00.

- Procedure code G6056, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $26.48. 125% of this amount is $33.10 at 4 units is $132.40.

- Procedure code G6056, service date February 25, 2015. The fee listed for this code in the Medicare Clinical Fee Schedule is $26.48. 125% of this amount is $33.10.

The total allowable reimbursement for the services in dispute is $848.15. This amount less the amount previously paid by the insurance carrier of $828.94 on November 11, 2015 leaves an amount due to the requestor of $19.21. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $19.21.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $19.21 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November 18, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.